FOR OHF USE

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2001
STATE OF ILLINOIS
DEPARTMENT OF PUBLIC AID
FINANCIAL AND STATISTICAL REPORT FOR LONG-TERM CARE FACILITIES
(FISCAL YEAR 2001)

IMPORTANT NOTICE
THIS AGENCY IS REQUESTING DISCLOSURE OF INFORMATION THAT IS NECESSARY TO ACCOMPLISH THE STATUTORY PURPOSE AS OUTLINED IN 210 ILCS 45/3-208. DISCLOSURE OF THIS INFORMATION IS MANDATORY. FAILURE TO PROVIDE ANY INFORMATION ON OR BEFORE THE DUE DATE WILL RESULT IN CESSATION OF PROGRAM PAYMENTS. THIS FORM HAS BEEN APPROVED BY THE FORMS MANAGEMENT CENTER.

I. IDPH Facility ID Number: 0029660

Facility Name: MAYFIELD CARE CENTER

Address: 5905 W. WASHINGTON B (Number) CHICAGO (City) 60644 (Zip Code)

County: COOK

Telephone Number: (773) 261-7074 **Fax #** (773) 261-2116

IDPA ID Number: 363336671001

Date of Initial License for Current Owners: 01/01/85

Type of Ownership:

	VOLUNTARY,NON-PROFIT	X	PROPRIETARY		GOVERNMENTAL
	Charitable Corp.		Individual		State
	Trust		Partnership		County
IRS Exemption Code			Corporation		Other
		X	"Sub-S" Corp.		
			Limited Liability Co.		
			Trust		
			Other		

In the event there are further questions about this report, please contact:
Name: Steve Lavenda **Telephone Number:** (847) 236 - 1111

II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER

I have examined the contents of the accompanying report to the State of Illinois, for the period from 01/01/01 to 12/31/01 and certify to the best of my knowledge and belief that the said contents are true, accurate and complete statements in accordance with applicable instructions. Declaration of preparer (other than provider) is based on all information of which preparer has any knowledge.

Intentional misrepresentation or falsification of any information in this cost report may be punishable by fine and/or imprisonment.

Officer or Administrator of Provider
(Signed) _____ (Date)
(Type or Print Name) _____
(Title) _____

Paid Preparer
(Signed) See Accountants' Compilation Report Attached (Date)
(Print Name and Title) CARY N. DRAZNER, C.P.A.
(Firm Name & Address) Frost, Ruttenberg & Rothblatt, P.C.
111 Pfingsten Road, Suite 300 Deerfield, IL 60015
(Telephone) (847) 236-1111 Fax# (847) 236-1155

MAIL TO: OFFICE OF HEALTH FINANCE
ILLINOIS DEPARTMENT OF PUBLIC AID
201 S. Grand Avenue East
Springfield, IL 62763-0001 **Phone # (217) 782-1630**

Facility Name & ID Number MAYFIELD CARE CENTER # 0029660 Report Period Beginning: 01/01/01 Ending: 12/31/01

III. STATISTICAL DATA

A. Licensure/certification level(s) of care; enter number of beds/bed days, (must agree with license). Date of change in licensed beds _____

	1 Beds at Beginning of Report Period	2 Licensure Level of Care	3 Beds at End of Report Period	4 Licensed Bed Days During Report Period	
1	104	Skilled (SNF)	104	37,960	1
2		Skilled Pediatric (SNF/PED)			2
3	52	Intermediate (ICF)	52	18,980	3
4		Intermediate/DD			4
5		Sheltered Care (SC)			5
6		ICF/DD 16 or Less			6
7	156	TOTALS	156	56,940	7

B. Census-For the entire report period.

	1 Level of Care	2 Patient Days by Level of Care and Primary Source of Payment: Public Aid Recipient	3 Private Pay	4 Other	5 Total	
8	SNF	20,603	506	3,222	24,331	8
9	SNF/PED					9
10	ICF	23,128		6,191	29,319	10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	43,731	506	9,413	53,650	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4. 94.22%

D. How many bed-hold days during this year were paid by Public Aid?
1296 (Do not include bed-hold days in Section B.)

E. List all services provided by your facility for non-patients.
(E.g., day care, "meals on wheels", outpatient therapy)
N/A

F. Does the facility maintain a daily midnight census? Yes

G. Do pages 3 & 4 include expenses for services or investments not directly related to patient care?
YES [ ] NO [X]

H. Does the BALANCE SHEET (page 17) reflect any non-care assets?
YES [ ] NO [X]

I. On what date did you start providing long term care at this location?
Date started 1/1/85

J. Was the facility purchased or leased after January 1, 1978?
YES [X] Date 1/1/85 NO [ ]

K. Was the facility certified for Medicare during the reporting year?
YES [X] NO [ ] If YES, enter number of beds certified 26 and days of care provided 2530

Medicare Intermediary AdminaStar Federal, Inc.

IV. ACCOUNTING BASIS

ACCRUAL [X] MODIFIED CASH* [ ] CASH* [ ]

Is your fiscal year identical to your tax year? YES [X] NO [ ]

Tax Year: 12/31/01 Fiscal Year: 12/31/01

* All facilities other than governmental must report on the accrual basis.

Facility Name & ID Number MAYFIELD CARE CENTER # 0029660 Report Period Beginning: 01/01/01 Ending: 12/31/01

V. COST CENTER EXPENSES (throughout the report, please round to the nearest dollar)

	Operating Expenses	Costs Per General Ledger				Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR OHF USE ONLY		
		Salary/Wage	Supplies	Other	Total							
	A. General Services	1	2	3	4	5	6	7	8	9	10	
1	Dietary	190,526	30,946	16,330	237,802		237,802		237,802			1
2	Food Purchase		271,959		271,959	(33,266)	238,693	(26)	238,667			2
3	Housekeeping	172,128	37,402		209,530		209,530	761	210,291			3
4	Laundry	66,724	10,808		77,532		77,532		77,532			4
5	Heat and Other Utilities			125,099	125,099		125,099	2,701	127,800			5
6	Maintenance	76,392	25,654	50,928	152,974		152,974	(3,172)	149,802			6
7	Other (specify):*							29	29			7
8	TOTAL General Services	505,770	376,769	192,357	1,074,896	(33,266)	1,041,630	293	1,041,923			8
	B. Health Care and Programs											
9	Medical Director			6,000	6,000		6,000		6,000			9
10	Nursing and Medical Records	1,764,728	109,625	41,835	1,916,188		1,916,188	(8,867)	1,907,321			10
10a	Therapy	98,669		2,814	101,483		101,483		101,483			10a
11	Activities	67,926	9,853	2,444	80,223		80,223		80,223			11
12	Social Services	65,134		4,567	69,701		69,701		69,701			12
13	Nurse Aide Training											13
14	Program Transportation											14
15	Other (specify):*											15
16	TOTAL Health Care and Programs	1,996,457	119,478	57,660	2,173,595		2,173,595	(8,867)	2,164,728			16
	C. General Administration											
17	Administrative	186,476		40,500	226,976		226,976	40,650	267,626			17
18	Directors Fees											18
19	Professional Services			394,373	394,373		394,373	(211,729)	182,644			19
20	Dues, Fees, Subscriptions & Promotions			54,022	54,022		54,022	(26,443)	27,579			20
21	Clerical & General Office Expenses	62,559	31,490	170,245	264,294		264,294	(71,151)	193,143			21
22	Employee Benefits & Payroll Taxes			480,030	480,030	33,266	513,296		513,296			22
23	Inservice Training & Education											23
24	Travel and Seminar			1,351	1,351		1,351	414	1,765			24
25	Other Admin. Staff Transportation			1,441	1,441		1,441	92	1,533			25
26	Insurance-Prop.Liab.Malpractice			123,305	123,305		123,305	27,720	151,025			26
27	Other (specify):*							31,914	31,914			27
28	TOTAL General Administration	249,035	31,490	1,265,267	1,545,792	33,266	1,579,058	(208,533)	1,370,525			28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	2,751,262	527,737	1,515,284	4,794,283		4,794,283	(217,107)	4,577,176			29

*Attach a schedule if more than one type of cost is included on this line, or if the total exceeds $1000.
NOTE: Include a separate schedule detailing the reclassifications made in column 5. Be sure to include a detailed explanation of each reclassification.

Facility Name & ID Number MAYFIELD CARE CENTER #0029660 Report Period Beginning: 01/01/01 Ending: 12/31/01

V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost Per General Ledger				Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR OHF USE ONLY		
		Salary/Wage	Supplies	Other	Total							
	D. Ownership	1	2	3	4	5	6	7	8	9	10	
30	Depreciation			20,517	20,517		20,517	220,669	241,186			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			8,466	8,466		8,466	425,236	433,702			32
33	Real Estate Taxes							40,951	40,951			33
34	Rent-Facility & Grounds			570,378	570,378		570,378	(570,378)				34
35	Rent-Equipment & Vehicles			33,242	33,242		33,242	(6,983)	26,259			35
36	Other (specify):*											36
37	**TOTAL Ownership**			632,603	632,603		632,603	109,495	742,098			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportati											38
39	Ancillary Service Centers		103,050	140,911	243,961		243,961		243,961			39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			85,410	85,410		85,410		85,410			42
43	Other (specify):*	102,580			102,580		102,580	(102,580)				43
44	**TOTAL Special Cost Centers**	102,580	103,050	226,321	431,951		431,951	(102,580)	329,371			44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	2,853,842	630,787	2,374,208	5,858,837		5,858,837	(210,192)	5,648,645			45

***Attach a schedule if more than one type of cost is included on this line, or if the total exceeds $1000.**

Facility Name & ID Numb MAYFIELD CARE CENTER # 0029660 Report Period Beginning: 01/01/01 Ending: 12/31/01

VI. ADJUSTMENT DETAIL

A. The expenses indicated below are non-allowable and should be adjusted out of Schedule V, pages 3 or 4 via column 7. In column 2 below, reference the line on which the particular cost was included. (See instructions.)

	NON-ALLOWABLE EXPENSES	1 Amount	2 Refer-ence	3 OHF USE ONLY	
1	Day Care	$		$	1
2	Other Care for Outpatients				2
3	Governmental Sponsored Special Programs				3
4	Non-Patient Meals				4
5	Telephone, TV & Radio in Resident Rooms				5
6	Rented Facility Space				6
7	Sale of Supplies to Non-Patients				7
8	Laundry for Non-Patients				8
9	Non-Straightline Depreciation	16,998	30		9
10	Interest and Other Investment Income	(4,564)	32		10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax	(26)	02		13
14	Non-Care Related Interest				14
15	Non-Care Related Owner's Transactions				15
16	Personal Expenses (Including Transportation)				16
17	Non-Care Related Fees				17
18	Fines and Penalties	(50)	21		18
19	Entertainment				19
20	Contributions	(13,437)	20		20
21	Owner or Key-Man Insurance				21
22	Special Legal Fees & Legal Retainers				22
23	Malpractice Insurance for Individuals				23
24	Bad Debt	(141,128)	21		24
25	Fund Raising, Advertising and Promotional	(10,253)	20		25
26	Income Taxes and Illinois Personal Property Replacement Tax	(7,656)	21		26
27	Nurse Aide Training for Non-Employees				27
28	Yellow Page Advertising				28
29	Other-Attach Schedule	(198,940)			29
30	SUBTOTAL (A): (Sum of lines 1-29)	$ (359,056)		$	30

OHF USE ONLY									
48		49		50		51		52	

B. If there are expenses experienced by the facility which do not appear in general ledger, they should be entered below.(See instructions.)

		1 Amount	2 Reference	
31	Non-Paid Workers-Attach Schedule*	$		31
32	Donated Goods-Attach Schedule*			32
33	Amortization of Organization & Pre-Operating Expense			33
34	Adjustments for Related Organization Costs (Schedule VII)	148,864		34
35	Other- Attach Schedule			35
36	SUBTOTAL (B): (sum of lines 31-35)	$ 148,864		36
37	TOTAL ADJUSTMENTS (sum of SUBTOTALS (A) and (B)	$ (210,192)		37

*These costs are only allowable if they are necessary to meet minimum licensing standards. Attach a schedule detailing the items included on these lines.

C. Are the following expenses included in Sections A to D of pages 3 and 4? If so, they should be reclassified into Section E. Please reference the line on which they appear before reclassification. (See instructions.)

		1 Yes	2 No	3 Amount	4 Reference	
38	Medically Necessary Transport.			$		38
39						39
40	Gift and Coffee Shops					40
41	Barber and Beauty Shops					41
42	Laboratory and Radiology					42
43	Prescription Drugs					43
44	Exceptional Care Program					44
45	Other-Attach Schedule					45
46	Other-Attach Schedule					46
47	TOTAL (C): (sum of lines 38-46)			$		47

MAYFIELD CARE CENTER

ID# 0029660

Report Period Beginning: 01/01/01

Ending: 12/31/01

	NON-ALLOWABLE EXPENSES	Amount	Sch. V Line Reference	
1	Capitalized Repairs & Maintenance	$ (6,677)	6	1
2	Marketing - Seminar Expense	(210)	24	2
3	Political Contributions	(3,256)	20	3
4	Marketing Salaries	(102,580)	43	4
5	Veteran's Medical Expense	(9,076)	10	5
6	Miscellaneous Income	(66)	21	6
7	Auto Lease Expense	(8,079)	35	7
8	Non-allowable Billing Expense	(5,000)	21	8
9	Amortization - Bldg. Co.	(63,996)	31	9
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STATE OF ILLINOIS

Summary A

Facility Name & ID Numb MAYFIELD CARE CENTER # 0029660 Report Period Beginning: 01/01/01 Ending: 12/31/01

SUMMARY OF PAGES 5, 5A, 6, 6A, 6B, 6C, 6D, 6E, 6F, 6G, 6H AND 6I

	Operating Expenses	PAGES	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	SUMMARY TOTALS	
	A. General Services	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	(to Sch V, col.7)	
1	Dietary													1
2	Food Purchase	(26)											(26)	2
3	Housekeeping			761									761	3
4	Laundry													4
5	Heat and Other Utilities			1,237		1,464							2,701	5
6	Maintenance	(6,677)		2,854		651							(3,172)	6
7	Other (specify):*					29							29	7
8	TOTAL General Services	(6,703)		4,852		2,144							293	8
	B. Health Care and Programs													
9	Medical Director													9
10	Nursing and Medical Records	(9,076)		209									(8,867)	10
10a	Therapy													10a
11	Activities													11
12	Social Services													12
13	Nurse Aide Training													13
14	Program Transportation													14
15	Other (specify):*													15
16	TOTAL Health Care and Progr	(9,076)		209									(8,867)	16
	C. General Administration													
17	Administrative			58,889	(18,800)	561							40,650	17
18	Directors Fees													18
19	Professional Services		7,336	(219,610)	143	402							(211,729)	19
20	Fees, Subscriptions & Promotion	(26,946)		467	18	18							(26,443)	20
21	Clerical & General Office Expen	(153,900)	24	82,603	15	107							(71,151)	21
22	Employee Benefits & Payroll Tax													22
23	Inservice Training & Education													23
24	Travel and Seminar	(210)		624									414	24
25	Other Admin. Staff Transportatio			92									92	25
26	Insurance-Prop.Liab.Malpractice		26,836	768		116							27,720	26
27	Other (specify):*			31,175	739								31,914	27
28	TOTAL General Administratio	(181,056)	34,196	(44,992)	(17,885)	1,204							(208,533)	28
29	TOTAL Operating Expense (sum of lines 8,16 & 28)	(196,835)	34,196	(39,931)	(17,885)	3,348							(217,107)	29

STATE OF ILLINOIS

Summary B

Facility Name & ID Number MAYFIELD CARE CENTER # 0029660 Report Period Beginning: 01/01/01 Ending: 12/31/01

SUMMARY OF PAGES 5, 5A, 6, 6A, 6B, 6C, 6D, 6E, 6F, 6G, 6H AND 6I

	Capital Expense	PAGES 5 & 5A	PAGE 6	PAGE 6A	PAGE 6B	PAGE 6C	PAGE 6D	PAGE 6E	PAGE 6F	PAGE 6G	PAGE 6H	PAGE 6I	SUMMARY TOTALS (to Sch V, col.7)	
	D. Ownership													
30	Depreciation	16,998	196,368	5,846	57	1,400							220,669	30
31	Amortization of Pre-Op. & Org.	(63,996)	63,996											31
32	Interest	(4,564)	426,900	297		2,603							425,236	32
33	Real Estate Taxes		39,017			1,934							40,951	33
34	Rent-Facility & Grounds		(570,378)	11,029		(11,029)							(570,378)	34
35	Rent-Equipment & Vehicles	(8,079)		1,096									(6,983)	35
36	Other (specify):*													36
37	**TOTAL Ownership**	(59,641)	155,903	18,268	57	(5,092)							109,495	37
	Ancillary Expense													
	E. Special Cost Centers													
38	Medically Necessary Transportatio													38
39	Ancillary Service Centers													39
40	Barber and Beauty Shops													40
41	Coffee and Gift Shops													41
42	Provider Participation Fee													42
43	Other (specify):*	(102,580)											(102,580)	43
44	**TOTAL Special Cost Centers**	(102,580)											(102,580)	44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	(359,056)	190,099	(21,663)	(17,828)	(1,744)							(210,192)	45

Facility Name & ID Number MAYFIELD CARE CENTER # 0029660 Report Period Beginning 01/01/01 Ending: 12/31/01

VII. RELATED PARTIES

A. Enter below the names of ALL owners and related organizations (parties) as defined in the instructions. Attach an additional schedule if necessary.

1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES		
Name	Ownership %	Name	City	Name	City	Type of Business
See Attached		See Attached		See Attached		

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. [X] YES [ ] NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
1	V	34	Rent	$ 503,373	Mayfield Building	100.00%	$	$ (503,373)	1
2	V	34	Rent-R/E Taxes	67,005	Mayfield Building	100.00%		(67,005)	2
3	V	19	Accounting		Mayfield Building	100.00%	7,336	7,336	3
4	V	31	Amortization		Mayfield Building	100.00%	63,996	63,996	4
5	V	33	Real Estate Taxes		Mayfield Building	100.00%	39,017	39,017	5
6	V	32	Interest		Mayfield Building	100.00%	426,900	426,900	6
7	V	21	Office		Mayfield Building	100.00%	24	24	7
8	V	26	Mortgage Insurance		Mayfield Building	100.00%	26,836	26,836	8
9	V	30	Depreciation		Mayfield Building	100.00%	196,368	196,368	9
10	V								10
11	V								11
12	V								12
13	V								13
14	Total			$ 570,378			$ 760,477	$ * 190,099	14

* Total must agree with the amount recorded on line 34 of Schedule VI.

Facility Name & ID Number MAYFIELD CARE CENTER # 0029660 Report Period Beginni 01/01/01 Ending: 12/31/01

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. [X] YES [ ] NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V	3	HOUSEKEEPING	$	MANAGCARE, INC.	100.00%	$ 761	$ 761	15
16	V	5	UTILITIES		MANAGCARE, INC.	100.00%	1,237	1,237	16
17	V	6	REPAIRS AND MAINT.		MANAGCARE, INC.	100.00%	2,854	2,854	17
18	V	10	NURSING SALARIES		MANAGCARE, INC.	100.00%	209	209	18
19	V	17	ADMINISTRATIVE		MANAGCARE, INC.	100.00%	56,498	56,498	19
20	V	19	PROFESSIONAL FEES		MANAGCARE, INC.	100.00%	1,670	1,670	20
21	V	20	FEES, SUBSCRIPTIONS		MANAGCARE, INC.	100.00%	467	467	21
22	V	21	CLERICAL AND GENERAL		MANAGCARE, INC.	100.00%	82,603	82,603	22
23	V	24	SEMINARS		MANAGCARE, INC.	100.00%	624	624	23
24	V	25	ADMIN. STAFF TRANS.		MANAGCARE, INC.	100.00%	92	92	24
25	V	26	INSURANCE		MANAGCARE, INC.	100.00%	768	768	25
26	V	27	GEN. ADMIN. EMP. BEN.		MANAGCARE, INC.	100.00%	31,175	31,175	26
27	V	30	DEPRECIATION		MANAGCARE, INC.	100.00%	5,846	5,846	27
28	V	32	INTEREST EXPENSE		MANAGCARE, INC.	100.00%	297	297	28
29	V	34	RENT - BUILDING (RELATED)		MANAGCARE, INC.	100.00%	11,029	11,029	29
30	V	35	EQUIPMENT RENTAL		MANAGCARE, INC.	100.00%	1,096	1,096	30
31	V	19	HOME OFFICE	221,280	MANAGCARE, INC.	100.00%		(221,280)	31
32	V	17	ADMIN. SALARY - MOSHE DAVIS		MANAGCARE, INC.	100.00%	2,391	2,391	32
33	V	17	ADMIN. SALARY - JOSHUA DAVIS		MANAGCARE, INC.	100.00%			33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			$ 221,280			$ 199,617	$ * (21,663)	39

* Total must agree with the amount recorded on line 34 of Schedule VI.

Facility Name & ID Number MAYFIELD CARE CENTER # 0029660 Report Period Beginni 01/01/01 Ending: 12/31/01

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. [X] YES [ ] NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V	17	ADMINISTRATIVE	$	INTERCARE, LTD. C/O MANAGCARE	100.00%	$ 21,700	$ 21,700	15
16	V	19	PROFESSIONAL FEES		INTERCARE, LTD. C/O MANAGCARE	100.00%	143	143	16
17	V	20	FEES, SUBSCRIPTIONS		INTERCARE, LTD. C/O MANAGCARE	100.00%	18	18	17
18	V	21	CLERICAL & GENERAL		INTERCARE, LTD. C/O MANAGCARE	100.00%	15	15	18
19	V	27	EMPLOYEE BENEFITS		INTERCARE, LTD. C/O MANAGCARE	100.00%	739	739	19
20	V	30	DEPRECIATION		INTERCARE, LTD. C/O MANAGCARE	100.00%	57	57	20
21	V								21
22	V	17	MANAGEMENT FEES	40,500	INTERCARE, LTD. C/O MANAGCARE	100.00%		(40,500)	22
23	V								23
24	V								24
25	V								25
26	V								26
27	V								27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			$ 40,500			$ 22,672	$ * (17,828)	39

* Total must agree with the amount recorded on line 34 of Schedule VI.

Facility Name & ID Number MAYFIELD CARE CENTER # 0029660 Report Period Beginni 01/01/01 Ending: 12/31/01

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. [X] YES [ ] NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V	5	UTILITIES	$	MAZEL MANAGEMENT	100.00%	$ 1,464	$ 1,464	15
16	V	6	REPAIRS & MAINT.		MAZEL MANAGEMENT		651	651	16
17	V	7	EMPLOYEE BEN.-R&M SAL.		MAZEL MANAGEMENT		29	29	17
18	V	17	ADMIN.-M. WOLF		MAZEL MANAGEMENT		561	561	18
19	V	19	PROFESSIONAL FEES		MAZEL MANAGEMENT		402	402	19
20	V	20	FEES, SUBSCRIPTIONS		MAZEL MANAGEMENT		18	18	20
21	V	21	CLERICAL & GENERAL		MAZEL MANAGEMENT		107	107	21
22	V	26	INSURANCE		MAZEL MANAGEMENT		116	116	22
23	V	30	DEPRECIATION		MAZEL MANAGEMENT		1,400	1,400	23
24	V	32	INTEREST EXPENSE		MAZEL MANAGEMENT		2,603	2,603	24
25	V	33	REAL ESTATE TAXES		MAZEL MANAGEMENT		1,934	1,934	25
26	V	34	RENT	11,029	MAZEL MANAGEMENT			(11,029)	26
27	V								27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			$ 11,029			$ 9,285	$ * (1,744)	39

* Total must agree with the amount recorded on line 34 of Schedule VI.

Facility Name & ID Number MAYFIELD CARE CENTER # 0029660 Report Period Beginni 01/01/01 Ending: 12/31/01

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. ☐ YES ☐ NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V			$			$	$	15
16	V								16
17	V								17
18	V								18
19	V								19
20	V								20
21	V								21
22	V								22
23	V								23
24	V								24
25	V								25
26	V								26
27	V								27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			$			$	$ *	39

* Total must agree with the amount recorded on line 34 of Schedule VI.

Facility Name & ID Number MAYFIELD CARE CENTER # 0029660 Report Period Beginni 01/01/01 Ending: 12/31/01

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. ☐ YES ☐ NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V			$			$	$	15
16	V								16
17	V								17
18	V								18
19	V								19
20	V								20
21	V								21
22	V								22
23	V								23
24	V								24
25	V								25
26	V								26
27	V								27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			$			$	$ *	39

* Total must agree with the amount recorded on line 34 of Schedule VI.

Facility Name & ID Number MAYFIELD CARE CENTER # 0029660 Report Period Beginni 01/01/01 Ending: 12/31/01

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. ☐ YES ☐ NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V			$			$	$	15
16	V								16
17	V								17
18	V								18
19	V								19
20	V								20
21	V								21
22	V								22
23	V								23
24	V								24
25	V								25
26	V								26
27	V								27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			$			$	$ *	39

* Total must agree with the amount recorded on line 34 of Schedule VI.

Facility Name & ID Number MAYFIELD CARE CENTER # 0029660 Report Period Beginni 01/01/01 Ending: 12/31/01

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. ☐ YES ☐ NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V			$			$	$	15
16	V								16
17	V								17
18	V								18
19	V								19
20	V								20
21	V								21
22	V								22
23	V								23
24	V								24
25	V								25
26	V								26
27	V								27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			$			$	$ *	39

* Total must agree with the amount recorded on line 34 of Schedule VI.

Facility Name & ID Number MAYFIELD CARE CENTER # 0029660 Report Period Beginni 01/01/01 Ending: 12/31/01

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. ☐ YES ☐ NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V			$			$	$	15
16	V								16
17	V								17
18	V								18
19	V								19
20	V								20
21	V								21
22	V								22
23	V								23
24	V								24
25	V								25
26	V								26
27	V								27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			$			$	$ *	39

* Total must agree with the amount recorded on line 34 of Schedule VI.

Facility Name & ID Number MAYFIELD CARE CENTER # 0029660 Report Period Beginni 01/01/01 Ending: 12/31/01

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. ☐ YES ☐ NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V			$			$	$	15
16	V								16
17	V								17
18	V								18
19	V								19
20	V								20
21	V								21
22	V								22
23	V								23
24	V								24
25	V								25
26	V								26
27	V								27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			$			$	$ *	39

* Total must agree with the amount recorded on line 34 of Schedule VI.

Facility Name & ID Number MAYFIELD CARE CENTER # 0029660 Report Period Beginning 01/01/01 Ending: 12/31/01

VII. RELATED PARTIES (continued)

C. Statement of Compensation and Other Payments to Owners, Relatives and Members of Board of Directors.

NOTE: ALL owners (even those with less than 5% ownership) and their relatives who receive any type of compensation from this home must be listed on this schedule.

	1	2	3	4	5	6		7		8	
						Average Hours Per Work Week Devoted to this Facility and % of Total Work Week		Compensation Included in Costs for this Reporting Period**			
	Name	Title	Function	Ownership Interest	Compensation Received From Other Nursing Homes*	Hours	Percent	Description	Amount	Schedule V. Line & Column Reference	
1	Yosef Davis	Shareholder	Mgmt/Admin	69.32%	See Attached	5	8.33%	Alloc. Sal	$ 21,700	17-7	1
2	Yosef Davis	Shareholder	Mgmt/Admin	69.32%	See Attached	5	8.33%	Salary	15,000	17-1	2
3	Moshe Davis	Shareholder	Administrative	0.25%	See Attached	13.7	34.25%	Alloc. Sal	2,391	17-7	3
4	Moshe Davis	Shareholder	Administrative	0.25%	See Attached	13.7	34.25%	Salary	48,118	17-1	4
5	Moshe Wolf	Shareholder	Administrative	1.34%	See Attached	12	21.43%	Alloc. Sal	15,136	17-7	5
6	Moshe Wolf	Shareholder	Administrative	1.34%	See Attached	12	21.43%	Alloc. Sal	561	17-7	6
7	Renita O'Connell	Shareholder	Administrative	1.34%	See Attached	9	22.50%	Alloc. Sal	16,612	17-7	7
8	Shoshana Braun	Shareholder	Clerical	0.25%	See Attached	4.5	13.35%	Alloc. Sal	3,875	21-1	8
9											9
10											10
11											11
12											12
13								TOTAL	$ 123,393		13

* If the owner(s) of this facility or any other related parties listed above have received compensation from other nursing homes, attach a schedule detailing of the home(s) as well as the amount paid. THIS AMOUNT MUST AGREE TO THE AMOUNTS CLAIMED ON THE THE OTHER NURSING HOMES' COST REI

** This must include all forms of compensation paid by related entities and allocated to Schedule V of this report (i.e., management fees). FAILURE TO PROPERLY COMPLETE THIS SCHEDULE INDICATING ALL FORMS OF COMPENSATION RECEIVED FROM THIS HOME, ALL OTHER NURSING HOMES AND MANAGEMENT COMPANIES MAY RESULT IN THE DISALLOWANCE OF SUCH COMPENSATION

Facility Name & ID Number MAYFIELD CARE CENTER # 0029660 Report Period Beginning: 01/01/01 Ending: 12/31/01

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES [ ] NO [X]

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization
Street Address
City / State / Zip Code
Phone Number ( )
Fax Number ( )

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1						$	$		$	1
2										2
3										3
4										4
5										5
6										6
7										7
8										8
9										9
10										10
11										11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$	$		$	25

Facility Name & ID Number MAYFIELD CARE CENTER # 0029660 Report Period Beginning: 01/01/01 Ending: 12/31/01

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES [X] NO [ ]

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization MANAGCARE, INC.
Street Address 3553 W. PETERSON AVE -3RD FLR
City / State / Zip Code CHICAGO, IL. 60659
Phone Number (773) 463-1313
Fax Number (773) 463- 5311

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1	3	HOUSEKEEPING	BOOKEEPING INC.	1,010,160	4	$ 3,472	$	221,280	$ 761	1
2	5	UTILITIES	BOOKEEPING INC.	1,010,160	4	5,647		221,280	1,237	2
3	6	REPAIRS AND MAINT.	BOOKEEPING INC.	1,010,160	4	13,027		221,280	2,854	3
4	10	NURSING SALARIES	BOOKEEPING INC.	1,010,160	4	956	956	221,280	209	4
5	17	ADMINISTRATIVE	BOOKEEPING INC.	1,010,160	4	257,918	257,918	221,280	56,498	5
6	19	PROFESSIONAL FEES	BOOKEEPING INC.	1,010,160	4	7,622		221,280	1,670	6
7	20	FEES, SUBSCRIPTIONS	BOOKEEPING INC.	1,010,160	4	2,131		221,280	467	7
8	21	CLERICAL AND GENERAL	BOOKEEPING INC.	1,010,160	4	377,089	309,593	221,280	82,603	8
9	24	SEMINARS	BOOKEEPING INC.	1,010,160	4	2,850		221,280	624	9
10	25	ADMIN. STAFF TRANS.	BOOKEEPING INC.	1,010,160	4	419		221,280	92	10
11	26	INSURANCE	BOOKEEPING INC.	1,010,160	4	3,506		221,280	768	11
12	27	GEN. ADMIN. EMP. BEN.	BOOKEEPING INC.	1,010,160	4	142,315		221,280	31,175	12
13	30	DEPRECIATION	BOOKEEPING INC.	1,010,160	4	26,685		221,280	5,846	13
14	32	INTEREST EXPENSE	BOOKEEPING INC.	1,010,160	4	1,357		221,280	297	14
15	34	RENT - BUILDING (RELATI	BOOKEEPING INC.	1,010,160	4	50,350		221,280	11,029	15
16	35	EQUIPMENT RENTAL	BOOKEEPING INC.	1,010,160	4	5,005		221,280	1,096	16
17										17
18	17	ADMIN. SALARY - MOSHE	AVG HRS WORKED	40	4	6,985	6,985	14	2,391	18
19	17	ADMIN. SALARY - JOSHUA	AVG HRS WORKED	40	4	7,104	7,104			19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$ 914,438	$ 582,556		$ 199,617	25

Facility Name & ID Number MAYFIELD CARE CENTER # 0029660 Report Period Beginning: 01/01/01 Ending: 12/31/01

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES [X] NO [ ]

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization: INTERCARE, LTD. C/O MANAGCARE
Street Address: 3553 W. PETERSON AVE. 3RD FLOOR
City / State / Zip Code: CHICAGO, IL. 60659
Phone Number: (773) 463-1313
Fax Number: (773) 463- 5311

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1	17	ADMINISTRATIVE	AVG. HOURS WORKED	60	6	$ 260,400	$ 260,400	5	$ 21,700	1
2	19	PROFESSIONAL FEES	AVG. HOURS WORKED	60	6	1,715		5	143	2
3	20	FEES, SUBSCRIPTIONS	AVG. HOURS WORKED	60	6	218		5	18	3
4	21	CLERICAL & GENERAL	AVG. HOURS WORKED	60	6	178		5	15	4
5	27	EMPLOYEE BENEFITS	AVG. HOURS WORKED	60	6	8,871		5	739	5
6	30	DEPRECIATION	AVG. HOURS WORKED	60	6	678		5	57	6
7										7
8										8
9										9
10										10
11										11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$ 272,060	$ 260,400		$ 22,672	25

Facility Name & ID Number MAYFIELD CARE CENTER # 0029660 Report Period Beginning: 01/01/01 Ending: 12/31/01

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES [X] NO [ ]

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization: MAZEL MANAGEMENT
Street Address: 3553 W.PETERSON AVE.
City / State / Zip Code: CHICAGO, IL. 60659
Phone Number: (773) 463-1313
Fax Number: (773) 463- 5311

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1	5	UTILITIES	MNGCR. BOOKPNG. IN(	1,010,160	4	$ 6,681	$	221,280	$ 1,464	1
2	6	REPAIRS & MAINT.	MNGCR. BOOKPNG. IN(	1,010,160	4	2,971	1,747	221,280	651	2
3	7	EMPLOYEE BEN.-R&M SAI	MNGCR. BOOKPNG. IN(	1,010,160	4	134		221,280	29	3
4	17	ADMIN.-M. WOLF	MNGCR. BOOKPNG. IN(	1,010,160	4	2,559		221,280	561	4
5	19	PROFESSIONAL FEES	MNGCR. BOOKPNG. IN(	1,010,160	4	1,837		221,280	402	5
6	20	FEES, SUBSCRIPTIONS	MNGCR. BOOKPNG. IN(	1,010,160	4	82		221,280	18	6
7	21	CLERICAL & GENERAL	MNGCR. BOOKPNG. IN(	1,010,160	4	489		221,280	107	7
8	26	INSURANCE	MNGCR. BOOKPNG. IN(	1,010,160	4	531		221,280	116	8
9	30	DEPRECIATION	MNGCR. BOOKPNG. IN(	1,010,160	4	6,392		221,280	1,400	9
10	32	INTEREST EXPENSE	MNGCR. BOOKPNG. IN(	1,010,160	4	11,883		221,280	2,603	10
11	33	REAL ESTATE TAXES	MNGCR. BOOKPNG. IN(	1,010,160	4	8,830		221,280	1,934	11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$ 42,389	$ 1,747		$ 9,285	25

Facility Name & ID Number MAYFIELD CARE CENTER # 0029660 Report Period Beginning: 01/01/01 Ending: 12/31/01

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES ☐ NO ☐

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization
Street Address
City / State / Zip Code
Phone Number ( )
Fax Number ( )

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1						$	$		$	1
2										2
3										3
4										4
5										5
6										6
7										7
8										8
9										9
10										10
11										11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$	$		$	25

Facility Name & ID Number MAYFIELD CARE CENTER # 0029660 Report Period Beginning: 01/01/01 Ending: 12/31/01

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES ☐ NO ☐

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization
Street Address
City / State / Zip Code
Phone Number ( )
Fax Number ( )

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1						$	$		$	1
2										2
3										3
4										4
5										5
6										6
7										7
8										8
9										9
10										10
11										11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$	$		$	25

Facility Name & ID Number MAYFIELD CARE CENTER # 0029660 Report Period Beginning: 01/01/01 Ending: 12/31/01

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES ☐ NO ☐

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization
Street Address
City / State / Zip Code
Phone Number ( )
Fax Number ( )

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1						$	$		$	1
2										2
3										3
4										4
5										5
6										6
7										7
8										8
9										9
10										10
11										11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$	$		$	25

Facility Name & ID Number MAYFIELD CARE CENTER # 0029660 Report Period Beginning: 01/01/01 Ending: 12/31/01

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES ☐ NO ☐

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization
Street Address
City / State / Zip Code
Phone Number ( )
Fax Number ( )

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1						$	$		$	1
2										2
3										3
4										4
5										5
6										6
7										7
8										8
9										9
10										10
11										11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$	$		$	25

Facility Name & ID Number MAYFIELD CARE CENTER # 0029660 Report Period Beginning: 01/01/01 Ending: 12/31/01

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES ☐ NO ☐

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization
Street Address
City / State / Zip Code
Phone Number ( )
Fax Number ( )

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1						$	$		$	1
2										2
3										3
4										4
5										5
6										6
7										7
8										8
9										9
10										10
11										11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$	$		$	25

Facility Name & ID Number MAYFIELD CARE CENTER # 0029660 Report Period Beginning: 01/01/01 Ending: 12/31/01

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES ☐ NO ☐

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization
Street Address
City / State / Zip Code
Phone Number ( )
Fax Number ( )

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1						$	$		$	1
2										2
3										3
4										4
5										5
6										6
7										7
8										8
9										9
10										10
11										11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$	$		$	25

Facility Name & ID Number MAYFIELD CARE CENTER # 0029660 Report Period Beginning: 01/01/01 Ending: 12/31/01

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE

A. Interest: (Complete details must be provided for each loan - attach a separate schedule if necessary.)

	1	2		3	4	5	6	7	8	9	10	
	Name of Lender	Related** YES	Related** NO	Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note Original	Amount of Note Balance	Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense	
	A. Directly Facility Related Long-Term											
1	First Mortgage		X	Mortgage			$	$ 5,352,166			$ 426,900	1
2	Manufacturers		X	Line of Credit				100,000			4,154	2
3												3
4												4
5												5
	Working Capital											
6	Manufacturers			Short Term Loan				800,000			4,312	6
7												7
8												8
9	TOTAL Facility Related						$	$ 6,252,166			$ 435,366	9
	B. Non-Facility Related*											
10	See Supplemental Schedule										(1,664)	10
11												11
12												12
13												13
14	TOTAL Non-Facility Related						$	$			$ (1,664)	14
15	TOTALS (line 9+line14)						$	$ 6,252,166			$ 433,702	15

* Any interest expense reported in this section should be adjusted out on page 5, line 14 and, consequently, page 4, col. 7. (See instructions.)

** If there is ANY overlap in ownership between the facility and the lender, this must be indicated in column 2. (See instructions.)

Facility Name & ID Number MAYFIELD CARE CENTER # 0029660 Report Period Beginning: 01/01/01 Ending: 12/31/01

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE

A. Interest: (Complete details must be provided for each loan - attach a separate schedule if necessary.)

	1	2		3	4	5	6	7	8	9	10	
	Name of Lender	Related**		Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note		Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense	
		YES	NO				Original	Balance				
1	Interest Income		X				$	$			$ (4,564)	1
2	Allocation - ManagCare	X									297	2
3	Allocation - Mazel	X									2,603	3
4												4
5												5
6												6
7												7
8												8
9												9
10												10
11												11
12												12
13												13
14												14
15												15
16												16
17												17
18												18
19												19
20												20
21							$	$			$ (1,664)	21

Facility Name & ID Numbe: MAYFIELD CARE CENTER # 0029660 Report Period Beginning: 01/01/01 Ending: 12/31/01

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE (continued)

B. Real Estate Taxes

1. Real Estate Tax accrual used on 2000 report.	***Important***, please see the next worksheet, "RE_Tax". The real estate tax statement and bill must accompany the cost report.	$ 47,000	1
2. Real Estate Taxes paid during the year: (Indicate the tax year to which this payment applies. If payment covers more than one year, detail below.)		$ 42,951	2
3. Under or (over) accrual (line 2 minus line 1).		$ (4,049)	3
4. Real Estate Tax accrual used for 2001 report. (Detail and explain your calculation of this accrual on the lines below.)		$ 45,000	4
5. Direct costs of an appeal of tax assessments which has NOT been included in professional fees or other general operating costs on Schedule V, sections A, B or C. **(Describe appeal cost below. Attach copies of invoices to support the cost and a copy of the appeal filed with the count**		$	5
6. Subtract a refund of real estate taxes. You must offset the full amount of any direct appeal costs classified as a real estate tax cost plus one-half of any remaining refund. **TOTAL REFUND $ For 19 Tax Year.** **(Attach a copy of the real estate tax appeal board's decision.)**		$	6
7. Real Estate Tax expense reported on Schedule V, line 33. This should be a combination of lines 3 thru 6.		$ 40,951	7

Real Estate Tax History:

Real Estate Tax Bill for Calendar Year:			
	1996	28,505	8
	1997	32,594	9
	1998	35,890	10
	1999	42,788	11
	2000	41,017	12

Line 2 includes Mazel Mgmt. Allocation of $1934

2001 Real Estate Tax Accrual: 41,017 X 1.1 = 45,000

	FOR OHF USE ONLY		
13	FROM R. E. TAX STATEMENT FOR 20(	$	13
14	PLUS APPEAL COST FROM LINE 5	$	14
15	LESS REFUND FROM LINE 6	$	15
16	AMOUNT TO USE FOR RATE CALCULA	$	16

NOTES:

1. **Please indicate a negative number by use of brackets( ). Deduct any overaccrual of taxes from prior year.**
2. **If facility is a non-profit which pays real estate taxes, you must attach a denial of an application for real estate tax exemption unless the building is rented from a for-profit entity.**
   This denial must be no more than four years old at the time the cost report is filed.

IMPORTANT NOTICE

TO: Long Term Care Facilities with Real Estate Tax Rates **RE:** 2000 REAL ESTATE TAX COST DOCUMENTATION

In order to set the real estate tax portion of the capital rate, it is necessary that we obtain additional information regarding your calendar 2000 real estate tax costs, as well as copies of your real estate tax bills for calendar 2000.

Please complete the Real Estate Tax Statement below and forward with a copy of your 2000 real estate tax bill to the Department of Public Aid, Office of Health Finance, 201 South Grand Avenue East, Springfield, Illinois 62763.

Please send these items in with your completed 2001 cost report. The cost report will not be

2000 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME MAYFIELD CARE CENTER COUNTY COOK

FACILITY IDPH LICENSE NUMBE 0029660

CONTACT PERSON REGARDING THIS REI Steve Lavenda

TELEPHONE (847) 236-1111 FAX #: (847) 236-1155

A. **Summary of Real Estate Tax Cost**

Enter the tax index number and real estate tax assessed for 2000 on the lines provided below. Enter only the p cost that applies to the operation of the nursing home in Column D. Real estate tax applicable to any portion c home property which is vacant, rented to other organizations, or used for purposes other than long term care n entered in Column D. Do not include cost for any period other than calendar year 2000.

	(A) Tax Index Number	(B) Property Description	(C) Total Tax	(D) Tax Applicable to Nursing Home
1.	16-08-419-002-0000	Long-Term Care Property	$ 604.04	$ 604.04
2.	16-08-419-003-0000	Long-Term Care Property	$ 9,019.05	$ 9,019.05
3.	16-08-419-004-0000	Long-Term Care Property	$ 13,064.21	$ 13,064.21
4.	16-08-419-005-0000	Long-Term Care Property	$ 9,099.89	$ 9,099.89
5.	16-08-419-006-0000	Long-Term Care Property	$ 6,937.94	$ 6,937.94
6.	16-08-419-007-0000	Long-Term Care Property	$ 2,047.85	$ 2,047.85
7.	See Attached	Allocation from ManagCare	$ 40,914.95	$ 2,055.12
8.			$	$
9.			$	$
10.			$	$
		TOTALS	$ 81,687.93	$ 42,828.10

B. **Real Estate Tax Cost Allocations**

Does any portion of the tax bill apply to more than one nursing home, vacant property, or property which is nc used for nursing home services? X YES _____ NO

If YES, attach an explanation & a schedule which shows the calculation of the cost allocated to the nursing ho (Generally the real estate tax cost must be allocated to the nursing home based upon sq. ft. of space used.)

C. **Tax Bills**

Attach a copy of the 2000 tax bills which were listed in Section A to this statement. Be sure to use the 2000 ta is normally paid during 2001.

Facility Name & ID Numb MAYFIELD CARE CENTER # 0029660 Report Period Beginning: 01/01/01 Ending: 12/31/01

X. BUILDING AND GENERAL INFORMATION:

A. Square Feet: _____ B. General Construction Type: Exterior Brick Frame _____ Number of Stories 4

C. Does the Operating Entity? [ ] (a) Own the Facility [X] (b) Rent from a Related Organization. [ ] (c) Rent from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI. Those checking (c) may complete Schedule XI or Schedule XII-A. See instructions.)

D. Does the Operating Entity? [X] (a) Own the Equipment [X] (b) Rent equipment from a Related Organization. [X] (c) Rent equipment from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI-C. Those checking (c) may complete Schedule XI-C or Schedule XII-B. See instructions.)

E. List all other business entities owned by this operating entity or related to the operating entity that are located on or adjacent to this nursing home's grounds (such as, but not limited to, apartments, assisted living facilities, day training facilities, day care, independent living facilities, nurse aide training facilities, etc.) List entity name, type of business, square footage, and number of beds/units available (where applicable).

None

F. Does this cost report reflect any organization or pre-operating costs which are being amortized? [ ] YES [X] NO
If so, please complete the following:

1. Total Amount Incurred: 128,202
2. Number of Years Over Which it is Being Amortized: _____
3. Current Period Amortization: _____
4. Dates Incurred: Allocated from Mayfield Building

Nature of Costs: _____
(Attach a complete schedule detailing the total amount of organization and pre-operating costs.)

XI. OWNERSHIP COSTS:

A. Land.

	1 Use	2 Square Feet	3 Year Acquired	4 Cost	
1	Facility		2000	$ 168,991	1
2					2
3	TOTALS			$ 168,991	3

Facility Name & ID Number MAYFIELD CARE CENTER # 0029660 Report Period Beginning: 01/01/01 Ending: 12/31/01

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Beds*	FOR OHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4	156		1999	1999	$ 1,595,648	$ 40,914	35	$ 79,782	$ 38,868	$ 212,752	4
5											5
6											6
7											7
8											8
	Improvement Type**										
9	Various			1985	11,950		20	664	664	11,075	9
10	Various			1986	24,199		20	1,273	1,273	19,628	10
11	Various			1987	12,137		20	392	392	5,714	11
12	Various			1988	38,957		20	1,258	(1,258)	17,073	12
13	Various			1989	57,789		20	2,890	2,890	36,249	13
14	Various			1990	40,078		20	1,391	1,391	22,939	14
15	Various			1991	34,073		20	1,704	1,704	17,467	15
16	Various			1992	1,200		20	60	60	590	16
17	Various			1993	6,071		20	304	304	2,543	17
18	Various			1994	24,281		20	1,214	1,214	8,774	18
19	Various			1995	1,467		20	73	73	470	19
20	Various			1996	64,140		20	3,207	3,207	17,773	20
21	Various			1997	15,923		20	796	796	3,627	21
22								-		-	22
23								-		-	23
24								-		-	24
25								-		-	25
26								-		-	26
27								-		-	27
28								-		-	28
29								-		-	29
30								-		-	30
31								-		-	31
32								-		-	32
33								-		-	33
34								-		-	34
35								-		-	35
36								-		-	36

*Total beds on this schedule must agree with page 2.

See Page 12A, Line 70 for total

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number MAYFIELD CARE CENTER # 0029660 Report Period Beginning: 01/01/01 Ending: 12/31/01

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
37			$	$		$ -	$	$ -	37
38						-		-	38
39						-		-	39
40						-		-	40
41						-		-	41
42						-		-	42
43						-		-	43
44						-		-	44
45						-		-	45
46						-		-	46
47						-		-	47
48						-		-	48
49						-		-	49
50						-		-	50
51						-		-	51
52						-		-	52
53						-		-	53
54						-		-	54
55						-		-	55
56						-		-	56
57						-		-	57
58						-		-	58
59						-		-	59
60						-		-	60
61						-		-	61
62						-		-	62
63						-		-	63
64						-		-	64
65						-		-	65
66						-		-	66
67						-		-	67
68	Related Party Allocations (Page 12-REP & Page 12A-REP)		57,588	2,937		2,484	(453)	36,272	68
69	Financial Statement Depreciation			52,103			(52,103)		69
70	TOTAL (lines 4 thru 69)		$ 1,985,501	$ 95,954		$ 97,492	$ (978)	$ 412,946	70

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number MAYFIELD CARE CENTER # 0029660 Report Period Beginning: 01/01/01 Ending: 12/31/01

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12A, Carried Forward		$ 1,985,501	$ 95,954		$ 97,492	$ 1,538	$ 412,946	1
2	ROOF REPAIRS	1998	2,400		20	120	120	480	2
3	BATHROOM FLOORING	1998	1,379		20	69	69	242	3
4	BATHROOM FLOORING	1998	6,482		20	324	324	1,134	4
5	ASPHALT PAVING	1998	12,815		20	641	641	2,137	5
6	ALARM SYSTE	1998	28,998		20	1,450	1,450	4,471	6
7	FIRE PUMP	1998	1,244		20	62	62	196	7
8	TILE,WALLPAPER,FIXT	1998	55,134		20	2,757	2,757	10,109	8
9	HANDRAIL	1998	2,500		20	125	125	438	9
10	HANDRAIL	1998	1,250		20	63	63	215	10
11	CHAIN LINK FENCE	1998	1,580		20	79	79	250	11
12	BLDG RENOVATION	1998	804,722		20	40,236	40,236	124,160	12
13	WALLPAPER	1998	5,240		20	262	262	961	13
14	TILE,WALLPAPER,FIXT	1998	6,695		20	335	335	1,200	14
15	WALLPAPER	1998	6,391		20	320	320	1,200	15
16	DRAPES	1998	12,491		20	625	625	2,235	16
17	DRAPES	1998	14,636		20	732	732	3,233	17
18	SPRINKLER HEADS	1998	1,791		20	90	90	330	18
19	LIGHT FIXTURES	1998	566		20	28	28	94	19
20	FIRE PUMP & MOTOR	1999	9,249		20	462	462	1,309	20
21	ELECTRICAL WORK	1999	5,351		20	268	268	715	21
22	FENCE	1999	6,975		20	349	349	960	22
23	FIRE ALARM SYSTEM	1999	5,563		20	278	278	718	23
24	STAIRWAY WORK	1999	2,850		20	143	143	429	24
25	FLOOR DRAINS	1999	2,000		20	100	100	258	25
26	ALARM	1999	4,507		20	225	225	675	26
27	VIDEO PROCESSOR	1999	3,832		20	192	192	416	27
28	DESK & CABINETS	1999	2,600		20	130	130	390	28
29	DESK & CABINETS	1999	5,825		20	291	291	606	29
30	BATHTUB	1999	1,220		20	61	61	137	30
31	ELECTRICAL ENGINEER	1999	1,260		20	63	63	163	31
32	PAINTING	1999	3,300		20	165	165	436	32
33	REMODELING	1999	40,449		20	2,022	2,022	5,224	33
34	TOTAL (lines 1 thru 33)		$ 3,046,796	$ 95,954		$ 150,559	$ 54,605	$ 578,467	34

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number MAYFIELD CARE CENTER # 0029660 Report Period Beginning: 01/01/01 Ending: 12/31/01

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12B, Carried Forward		$ 3,046,796	$ 95,954		$ 150,559	$ 54,605	$ 578,467	1
2	CONSTRUCT SUPPLIES	1999	1,223		20	61	61	158	2
3	ARCHITECT SUPPLIES	1999	2,082		20	104	104	269	3
4	CUBICLE CURTNS, TILE	1999	2,147		20	107	107	277	4
5	NURSE CALL SYSTEM	1999	419		20	21	21	48	5
6	ALARM SYSTEM	1999	1,081		20	54	54	180	6
7	PAINTING	1999	1,585		20	79	79	205	7
8	SEAL COATING	1999	1,791		20	90	90	255	8
9	INTERCOM SYSTEM	1999	847		20	42	42	120	9
10	VIDEO SECURITY SYSTM	1999	2,266		20	113	113	320	10
11	CCTV SYSTEM	1999	2,184		20	109	109	309	11
12	CCTV SYSTEM	1999	1,559		20	78	78	221	12
13	PUBLIC ADDRESS SYSTM	1999	880		20	44	44	124	13
14	WALK IN REFRIG REPAI	1999	1,405		20	70	70	210	14
15	COPPER PIPE	1999	1,475		20	74	74	222	15
16	TELECOMM SYSTEM	1999	1,105		20	55	55	146	16
17	FIRE PROTECTION	1999	3,290		20	165	165	508	17
18	HOT WATER SYSTEM	1999	1,576		20	79	79	290	18
19	ELECTRIC DOOR HOLDER	1999	527		20	26	26	56	19
20	CCTV SYSTEM	1999	1,154		20	58	58	126	20
21	NURSE CALL SYSTEM	1999	348		20	17	17	36	21
22	CCTV SYSTEM	1999	762		20	38	38	82	22
23	ALARM SYSTEM	1999	1,392		20	70	70	158	23
24	ROOF FLASHERS	1999	1,000		20	50	50	129	24
25	COPPER PIPE	1999	1,200		20	60	60	155	25
26	FIRE DAMPERS	2000	7,044		20	352	352	675	26
27	FIRE DAMPERS	2000	1,000		20	50	50	92	27
28	FIRE DAMPERS	2000	4,920		20	246	246	472	28
29	ALARM SYSTEM	2000	1,866		20	93	93	155	29
30	ELECTRICAL WORK	2000	4,814		20	241	241	362	30
31	NEW MAIN LINES	2000	2,775		20	139	139	220	31
32	SURVEY	2000	750		20	38	38	63	32
33	AWING	2000	8,500		20	850	850	1,629	33
34	TOTAL (lines 1 thru 33)		$ 3,111,763	$ 95,954		$ 154,232	$ 58,278	$ 586,739	34

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number MAYFIELD CARE CENTER # 0029660 Report Period Beginning: 01/01/01 Ending: 12/31/01

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12C, Carried Forward		$ 3,111,763	$ 95,954		$ 154,232	$ 58,278	$ 586,739	1
2	FENCE	2000	1,250		20	125	125	250	2
3	NEW PUMP UNIT	2000	6,800		20	680	680	1,020	3
4	CIRCUIT BREAKER/CMPR	2000	3,982		20	199	199	282	4
5	FIRE DAMPERS	2001	4,723		20	354	354	354	5
6	KITCHEN FAN	2001	2,000		20	100	100	100	6
7	CARPET	2001	1,049		20	17	17	17	7
8	ELEVATOR MOTOR	2001	1,800		20	8	8	8	8
9									9
10									10
11									11
12									12
13									13
14									14
15									15
16									16
17									17
18									18
19									19
20									20
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22									22
23									23
24									24
25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		$ 3,133,367	$ 95,954		$ 155,715	$ 59,761	$ 588,770	34

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number MAYFIELD CARE CENTER # 0029660 Report Period Beginning: 01/01/01 Ending: 12/31/01

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12D, Carried Forward		$ 3,133,367	$ 95,954		$ 155,715	$ 59,761	$ 588,770	1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
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23									23
24									24
25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		$ 3,133,367	$ 95,954		$ 155,715	$ 59,761	$ 588,770	34

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number MAYFIELD CARE CENTER # 0029660 Report Period Beginning: 01/01/01 Ending: 12/31/01

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12E, Carried Forward		$ 3,133,367	$ 95,954		$ 155,715	$ 59,761	$ 588,770	1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
13									13
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24									24
25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		$ 3,133,367	$ 95,954		$ 155,715	$ 59,761	$ 588,770	34

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number MAYFIELD CARE CENTER # 0029660 Report Period Beginning: 01/01/01 Ending: 12/31/01

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12F, Carried Forward		$ 3,133,367	$ 95,954		$ 155,715	$ 59,761	$ 588,770	1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
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24									24
25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		$ 3,133,367	$ 95,954		$ 155,715	$ 59,761	$ 588,770	34

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number MAYFIELD CARE CENTER # 0029660 Report Period Beginning: 01/01/01 Ending: 12/31/01

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12G, Carried Forward		$ 3,133,367	$ 95,954		$ 155,715	$ 59,761	$ 588,770	1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
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24									24
25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		$ 3,133,367	$ 95,954		$ 155,715	$ 59,761	$ 588,770	34

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number MAYFIELD CARE CENTER # 0029660 Report Period Beginning: 01/01/01 Ending: 12/31/01

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12H, Carried Forward		$ 3,133,367	$ 95,954		$ 155,715	$ 59,761	$ 588,770	1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
13									13
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22									22
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24									24
25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		$ 3,133,367	$ 95,954		$ 155,715	$ 59,761	$ 588,770	34

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number MAYFIELD CARE CENTER # 0029660 Report Period Beginning: 01/01/01 Ending: 12/31/01

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Beds*	FOR OHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4			1985		$ 22,600	$ 1,175	20	$ 753	$ (422)	$ 12,241	4
5					Allocation-Mazel						5
6											6
7											7
8											8
	Improvement Type**										
9											9
10	Allocation - ManagCare			1997	2,635	235	20	263	28	1,164	10
11	Allocation - ManagCare			1993	207		20	10	10	88	11
12	Allocation - ManagCare			1988	323	10	20	16	(6)	214	12
13	Allocation - ManagCare			1986	24,441	1,248	20	1,119	(129)	19,221	13
14											14
15	Allocation - Mazel Management			2001	475	5	20	12	7	12	15
16	Allocation - Mazel Management			2000	240	6	20	12	6	15	16
17	Allocation - Mazel Management			1998	845	29	20	42	13	157	17
18	Allocation - Mazel Management			1997	788	20	20	39	19	171	18
19	Allocation - Mazel Management			1996	538	9	20	27	18	150	19
20	Allocation - Mazel Management			1995	122	3	20	6	3	40	20
21	Allocation - Mazel Management			1994	480	9	20	24	15	155	21
22	Allocation - Mazel Management			1993	283	8	20	14	6	120	22
23	Allocation - Mazel Management			1991	212	7	20	10	3	104	23
24	Allocation - Mazel Management			1990	330	7	20	17	10	187	24
25	Allocation - Mazel Management			1989	206	5	20	9	4	109	25
26	Allocation - Mazel Management			1987	469	9	20	12	3	461	26
27	Allocation - Mazel Management			1986	1,894	99	20	93	(6)	1,525	27
28	Allocation - Mazel Management			1985	132					132	28
29											29
30	Allocation - Inter Care			2001	368	53	20	6	(47)	6	30
31											31
32											32
33											33
34											34
35											35
36											36

*Total beds on this schedule must agree with page 2.

See Page 12A-REP, Line 70 for total

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number MAYFIELD CARE CENTER # 0029660 Report Period Beginning: 01/01/01 Ending: 12/31/01

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
37			$	$		$	$	$	37
38									38
39									39
40									40
41									41
42									42
43									43
44									44
45									45
46									46
47									47
48									48
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56									56
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58									58
59									59
60									60
61									61
62									62
63									63
64									64
65									65
66									66
67									67
68									68
69									69
70	TOTAL (lines 4 thru 69)		$ 57,588	$ 2,937		$ 2,484	$ (465)	$ 36,272	70

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number MAYFIELD CARE CENTER # 0029660 Report Period Beginning: 01/01/01 Ending: 12/31/01

XI. OWNERSHIP COSTS (continued)

C. Equipment Depreciation-Excluding Transportation. (See instructions.)

	Category of Equipment	1 Cost	Current Book Depreciation 2	Straight Line Depreciation 3	4 Adjustments	Componen Life 5	Accumulated Depreciation 6	
71	Purchased in Prior Years	$ 909,438	$ 126,628	$ 83,532	$ (43,096)	10	$ 386,676	71
72	Current Year Purchases	11,971	73	1,040	967	10	1,040	72
73	Fully Depreciated Assets	31,714	4	4		10	31,668	73
74								74
75	TOTALS	$ 953,123	$ 126,705	$ 84,576	$ (42,129)		$ 419,384	75

D. Vehicle Depreciation (See instructions.)*

	1 Use	Model, Make and Year 2	Year Acquired 3	4 Cost	Current Book Depreciation 5	Straight Line Depreciation 6	7 Adjustments	Life in Years 8	Accumulated Depreciation 9	
76	Alloc. ManaCare			$ 10,446	$ 1,529	$ 895	$ (634)	5	$ 7,046	76
77										77
78										78
79										79
80	TOTALS			$ 10,446	$ 1,529	$ 895	$ (634)		$ 7,046	80

E. Summary of Care-Related Assets

		1 Reference	2 Amount		
81	Total Historical Cost	(line 3, col.4 + line 70, col.4 + line 75, col.1 + line 80, col.4) + (Pages 12B thru 12I, if applicable)	$ 4,265,927	81	
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	$ 224,188	82	
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	$ 241,186	83	**
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	$ 16,998	84	
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	$ 1,015,200	85	

F. Depreciable Non-Care Assets Included in General Ledger. (See instructions.)

	1 Description & Year Acquired	2 Cost	Current Book Depreciation 3	Accumulated Depreciation 4	
86	Certificate of Need - 1900	$ 905,000	$	$	86
87					87
88					88
89					89
90					90
91	TOTALS	$ 905,000	$	$	91

G. Construction-in-Progress

	Description	Cost	
92		$	92
93			93
94			94
95		$	95

* Vehicles used to transport residents to & from day training must be recorded in XI-F, not XI-D.

** This must agree with Schedule V line 30, column 8.

Facility Name & ID Number MAYFIELD CARE CENTER # 0029660 Report Period Beginning: 01/01/01 Ending: 12/31/01

XII. RENTAL COSTS

A. Building and Fixed Equipment (See instructions.)

1. Name of Party Holding Lease: Mayfield Building

2. Does the facility also pay real estate taxes in addition to rental amount shown below on line 7, column 4?
If NO, see instructions. [X] YES [ ] NO

		1 Year Constructed	2 Number of Beds	3 Date of Lease	4 Rental Amount	5 Total Years of Lease	6 Total Years Renewal Option*	
3	Original Building:				$			3
4	Additions							4
5								5
6								6
7	TOTAL				$ **			7

8. List separately any amortization of lease expense included on page 4, line 34. _____
This amount was calculated by dividing the total amount to be amortized _____
by the length of the lease _____.

9. Option to Buy: [ ] YES [ ] NO Terms: _____ *

10. Effective dates of current rental agreement:
Beginning _____
Ending _____

11. Rent to be paid in future years under the curr
rental agreement:

	Fiscal Year Ending	Annual Rent
12.	/2002	$
13.	/2003	$
14.	/2004	$

B. Equipment-Excluding Transportation and Fixed Equipment. (See instructions.)

15. Is Movable equipment rental included in building rental? [ ] YES [ ] NO

16. Rental Amount for movable equipment: 26,259 Description: Complex Medical Equipment - $25,162; Allocated from ManagCare $1097
(Attach a schedule detailing the breakdown of movable equipment)

C. Vehicle Rental (See instructions.)

	1 Use	2 Model Year and Make	3 Monthly Lease Payment	4 Rental Expense for this Period	
17			$	$	17
18					18
19					19
20					20
21	TOTAL		$	$	21

* If there is an option to buy the building, please provide complete details on attached schedule.

** This amount plus any amortization of lease expense must agree with page 4, line 34.

Facility Name & ID Number MAYFIELD CARE CENTER # 0029660 Report Period Beginning: 01/01/01 Ending: 12/31/01

XIII. EXPENSES RELATING TO NURSE AIDE TRAINING PROGRAMS (See instructions.)

A. TYPE OF TRAINING PROGRAM (If aides are trained in another facility program, attach a schedule listing the facility name, address and cost per aide trained in that facility.)

1. HAVE YOU TRAINED AIDES DURING THIS REPORT PERIOD?
   - [ ] YES
   - [X] NO

   If "yes", please complete the remainder of this schedule. If "no", provide an explanation as to why this training was not necessary.

2. CLASSROOM PORTION:
   - IN-HOUSE PROGRAM [ ]
   - IN OTHER FACILITY [ ]
   - COMMUNITY COLLEGE [ ]
   - HOURS PER AIDE ____

3. CLINICAL PORTION:
   - IN-HOUSE PROGRAM [ ]
   - IN OTHER FACILITY [ ]
   - HOURS PER AIDE ____

B. EXPENSES

ALLOCATION OF COSTS (d)

		1	2	3	4
		Facility			
		Drop-outs	Completed	Contract	Total
1	Community College Tuition	$	$	$	$
2	Books and Supplies				
3	Classroom Wages (a)				
4	Clinical Wages (b)				
5	In-House Trainer Wages (c)				
6	Transportation				
7	Contractual Payments				
8	Nurse Aide Competency Tests				
9	TOTALS	$	$	$	$
10	SUM OF line 9, col. 1 and 2 (e)	$			

C. CONTRACTUAL INCOME

In the box below record the amount of income yo facility received training aides from other faciliti

$

D. NUMBER OF AIDES TRAINED

COMPLETED	
1. From this facility	
2. From other facilities (f)	
DROP-OUTS	
1. From this facility	
2. From other facilities (f)	
TOTAL TRAINED	

(a) Include wages paid during the classroom portion of training. Do not include fringe benefits.
(b) Include wages paid during the clinical portion of training. Do not include fringe benefits.
(c) For in-house training programs only. Do not include fringe benefits.
(d) Allocate based on if the aide is from your facility or is being contracted to be trained in your facility. Drop-out costs can only be for costs incurred by your own aides.
(e) The total amount of Drop-out and Completed Costs for your own aides must agree with Sch. V, line 13, col. 8.
(f) Attach a schedule of the facility names and addresses of those facilities for which you trained aides.

Facility Name & ID Number MAYFIELD CARE CENTER # 0029660 Report Period Beginning: 01/01/01 Ending: 12/31/01

XIV. SPECIAL SERVICES (Direct Cost) (See instructions.)

	1	2	3	4	5	6	7	8	
	Service	Schedule V Line & Column Reference	Staff Units of Service	Staff Cost	Outside Practitioner (other than consultant) Units	Outside Practitioner (other than consultant) Cost	Supplies (Actual or) Allocated)	Total Units (Column 2 + 4	Total Cost (Col. 3 + 5 + 6)	
1	Licensed Occupational Therapist	39 - 03	hrs	$		$ 68,058	$		$ 68,058	1
2	Licensed Speech and Language Development Therapist	39 - 03	hrs			17,912			17,912	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist	39 - 03	hrs			54,941			54,941	4
5	Physician Care		visits							5
6	Dental Care		visits							6
7	Work Related Program		hrs							7
8	Habilitation		hrs							8
9	Pharmacy	39 - 02	# of prescrpts				47,644		47,644	9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Exceptional Care Program									12
13	Other (specify):						55,406		55,406	13
14	TOTAL			$		$ 140,911	$ 103,050		$ 243,961	14

NOTE: This schedule should include fees (other than consultant fees) paid to licensed practitioners. Consultant fees should be detailed on Schedule XVIII-B. Salaries of unlicensed practitioners, such as nurse aides, who help with the above activities should not be listed on this schedule.

Facility Name & ID Number MAYFIELD CARE CENTER # 0029660 Report Period Beginning: 01/01/01 Ending: 12/31/01

XV. BALANCE SHEET - Unrestricted Operating Fund. As of 12/31/01 (last day of reporting year)

This report must be completed even if financial statements are attached.

		1 Operating	2 After Consolidation*	
	A. Current Assets			
1	Cash on Hand and in Banks	$ 53,732	$ 864,099	1
2	Cash-Patient Deposits	5,473	5,473	2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance)	1,191,970	1,191,970	3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance	165,455	165,455	6
7	Other Prepaid Expenses	6,853	6,853	7
8	Accounts Receivable (owners or related parties	521	521	8
9	Other(specify): See supplemental schedule	461,725	461,728	9
10	**TOTAL Current Assets (sum of lines 1 thru 9)**	$ 1,885,729	$ 2,696,099	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land		273,991	13
14	Buildings, at Historical Cost		1,595,648	14
15	Leasehold Improvements, at Historical Cost	37,748	1,274,200	15
16	Equipment, at Historical Cost	63,171	985,255	16
17	Accumulated Depreciation (book methods)	(30,813)	(1,097,301)	17
18	Deferred Charges			18
19	Organization & Pre-Operating Costs			19
20	Accumulated Amortization - Organization & Pre-Operating Costs			20
21	Restricted Funds			21
22	Other Long-Term Assets (specify):			22
23	Other(specify): See supplemental schedule	172,675	1,042,691	23
24	**TOTAL Long-Term Assets (sum of lines 11 thru 23)**	$ 242,781	$ 4,074,484	24
25	**TOTAL ASSETS (sum of lines 10 and 24)**	$ 2,128,510	$ 6,770,583	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	$ 621,981	$ 621,984	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable	900,000	934,848	29
30	Accrued Salaries Payable	124,671	124,671	30
31	Accrued Taxes Payable (excluding real estate taxes)	20,981	20,981	31
32	Accrued Real Estate Taxes(Sch.IX-B)		45,000	32
33	Accrued Interest Payable			33
34	Deferred Compensation			34
35	Federal and State Income Taxes	11,047	11,047	35
	Other Current Liabilities(specify):			
36	See supplemental schedule			36
37				37
38	**TOTAL Current Liabilities (sum of lines 26 thru 37)**	$ 1,678,680	$ 1,758,531	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable		5,317,318	39
40	Mortgage Payable			40
41	Bonds Payable			41
42	Deferred Compensation			42
	Other Long-Term Liabilities(specify			
43	See supplemental schedule			43
44				44
45	**TOTAL Long-Term Liabilities (sum of lines 39 thru 44)**	$	$ 5,317,318	45
46	**TOTAL LIABILITIES (sum of lines 38 and 45)**	$ 1,678,680	$ 7,075,849	46
47	**TOTAL EQUITY(page 18, line 24**	$ 449,830	$ (305,266)	47
48	**TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)**	$ 2,128,510	$ 6,770,583	48

*(See instructions.)

Facility Name & ID Numb MAYFIELD CARE CENTER # 0029660 Report Period Beginning 01/01/01 Ending: 12/31/01

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	**Balance at Beginning of Year, as Previously Reported**	$ 399,521	1
2	Restatements (describe):		2
3	State Replacement Tax	570	3
4			4
5			5
6	**Balance at Beginning of Year, as Restated (sum of lines**	$ 400,091	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	489,739	7
8	Aquisitions of Pooled Companies		8
9	Proceeds from Sale of Stock		9
10	Stock Options Exercised		10
11	Contributions and Grants		11
12	Expenditures for Specific Purposes		12
13	Dividends Paid or Other Distributions to Owners	(440,000)	13
14	Donated Property, Plant, and Equipment		14
15	Other (describe)		15
16	Other (describe)		16
17	**TOTAL Additions (deductions) (sum of lines 7-16)**	$ 49,739	17
	B. Transfers (Itemize):		
18			18
19			19
20			20
21			21
22			22
23	**TOTAL Transfers (sum of lines 18-22)**	$	23
24	**BALANCE AT END OF YEAR (sum of lines 6 + 17 + 23**	$ 449,830	24 *

*** This must agree with page 17, line 47.**

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XVII. INCOME STATEMENT (attach any explanatory footnotes necessary to reconcile this schedule to Schedules V and VI.) All required classifications of revenue and expense must be provided on this form, even if financial statements are attached.

Note: This schedule should show gross revenue and expenses. Do not net revenue against expense

	Revenue	1 Amount	
	A. Inpatient Care		
1	Gross Revenue -- All Levels of Care	$ 6,211,733	1
2	Discounts and Allowances for all Levels	(434,273)	2
3	**SUBTOTAL Inpatient Care (line 1 minus line 2)**	$ 5,777,460	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	367,178	6
7	Oxygen		7
8	**SUBTOTAL Ancillary Revenue (lines 4 thru 7)**	$ 367,178	8
	C. Other Operating Revenue		
9	Payments for Education		9
10	Other Government Grants		10
11	Nurses Aide Training Reimbursements		11
12	Gift and Coffee Shop		12
13	Barber and Beauty Care		13
14	Non-Patient Meals		14
15	Telephone, Television and Radio		15
16	Rental of Facility Space		16
17	Sale of Drugs	47,489	17
18	Sale of Supplies to Non-Patients		18
19	Laboratory	91,227	19
20	Radiology and X-Ray		20
21	Other Medical Services	59,231	21
22	Laundry		22
23	**SUBTOTAL Other Operating Revenue (lines 9 th**	$ 197,947	23
	D. Non-Operating Revenue		
24	Contributions		24
25	Interest and Other Investment Income***	4,564	25
26	**SUBTOTAL Non-Operating Revenue (lines 24 an**	$ 4,564	26
	E. Other Revenue (specify):**		
27	Settlement Income (Insurance, Legal, Etc.)		27
28	See supplemental schedule	1,427	28
28a			28a
29	**SUBTOTAL Other Revenue (lines 27, 28 and 28a**	$ 1,427	29
30	**TOTAL REVENUE (sum of lines 3, 8, 23, 26 and**	$ 6,348,576	30

	Expenses	2 Amount	
	A. Operating Expenses		
31	General Services	1,074,896	31
32	Health Care	2,173,595	32
33	General Administration	1,545,792	33
	B. Capital Expense		
34	Ownership	632,603	34
	C. Ancillary Expense		
35	Special Cost Centers	346,541	35
36	Provider Participation Fee	85,410	36
	D. Other Expenses (specify):		
37			37
38			38
39			39
40	**TOTAL EXPENSES (sum of lines 31 thru 39)***	$ 5,858,837	40
41	**Income before Income Taxes (line 30 minus line 40)****	489,739	41
42	**Income Taxes**		42
43	**NET INCOME OR LOSS FOR THE YEAR (line 41 minus l**	$ 489,739	43

* **This must agree with page 4, line 45, column 4.**

** **Does this agree with taxable income (loss) per Federal Income Tax Return? Not Complet If not, please attach a reconciliation.**

*** **See the instructions. If this total amount has not been offset against interest expense on Schedule V, line 32, please include a detailed explanation.**

**** **Provide a detailed breakdown of "Other Revenue" on an attached sheet.**

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XVIII. A. STAFFING AND SALARY COSTS (Please report each line separately.)

(This schedule must cover the entire reporting period.)

		1 # of Hrs. Actually Worked	2** # of Hrs. Paid and Accrued	3 Reporting Period Total Salaries, Wages	4 Average Hourly Wage	
1	Director of Nursing	1,656	1,791	$ 50,455	$ 28.17	1
2	Assistant Director of Nursing	456	492	9,676	19.67	2
3	Registered Nurses	9,406	9,878	228,981	23.18	3
4	Licensed Practical Nurses	38,028	40,970	707,875	17.28	4
5	Nurse Aides & Orderlies	79,006	84,250	725,733	8.61	5
6	Nurse Aide Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides	7,555	8,424	98,669	11.71	8
9	Activity Director	2,057	2,184	23,233	10.64	9
10	Activity Assistants	5,568	5,990	44,693	7.46	10
11	Social Service Workers	6,421	6,938	65,134	9.39	11
12	Dietician					12
13	Food Service Supervisor					13
14	Head Cook					14
15	Cook Helpers/Assistants	20,826	23,014	190,526	8.28	15
16	Dishwashers					16
17	Maintenance Workers	10,305	10,864	76,392	7.03	17
18	Housekeepers	22,310	23,971	172,128	7.18	18
19	Laundry	9,395	10,181	66,724	6.55	19
20	Administrator	1,928	2,128	75,805	35.62	20
21	Assistant Administrator	2,024	2,160	43,418	20.10	21
22	Other Administrative	2,943	2,943	67,253	22.85	22
23	Office Manager					23
24	Clerical	5,406	5,888	62,559	10.62	24
25	Vocational Instruction					25
26	Academic Instruction					26
27	Medical Director					27
28	Qualified MR Prof. (QMRP)					28
29	Resident Services Coordinator					29
30	Habilitation Aides (DD Homes)					30
31	Medical Records	3,749	4,206	42,008	9.99	31
32	Other Health Care(specify)					32
33	Other(specify)	2,112	2,632	102,580	38.97	33
34	TOTAL (lines 1 - 33)	231,151	248,904	$ 2,853,842 *	$ 11.47	34

* This total must agree with page 4, column 1, line 45. ** See instructions.

B. CONSULTANT SERVICES

		1 Number of Hrs. Paid & Accrued	2 Total Consultant Cost for Reporting Period	3 Schedule V Line & Column Reference	
35	Dietary Consultant	340	$ 16,330	01-03	35
36	Medical Director	Monthly	6,000	09-03	36
37	Medical Records Consultant	Monthly	4,032	10-03	37
38	Nurse Consultant				38
39	Pharmacist Consultant	Monthly	3,503	10-03	39
40	Physical Therapy Consultant	15	763	10a-03	40
41	Occupational Therapy Consultant	34	1,713	10a-03	41
42	Respiratory Therapy Consultant				42
43	Speech Therapy Consultant				43
44	Activity Consultant	45	2,444	11-03	44
45	Social Service Consultant	68	3,728	12-03	45
46	Other(specify)				46
47	REHABILITATION CONS.	7	339	10a-03	47
48	PSYCHO-SOCIAL CONS.	15	838	12-03	48
49	TOTAL (lines 35 - 48)	524	$ 39,690		49

C. CONTRACT NURSES

		1 Number of Hrs. Paid & Accrued	2 Total Contract Wages	3 Schedule V Line & Column Reference	
50	Registered Nurses	8	$ 384	10-03	50
51	Licensed Practical Nurses	1,042	33,916	10-03	51
52	Nurse Aides				52
53	TOTAL (lines 50 - 52)	1,050	$ 34,300		53

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XIX. SUPPORT SCHEDULES

A. Administrative Salaries

Name	Function	Ownership %	Amount
Joshua Weinstein	Administrator	0	$ 75,180
Patty Holly	Asst. Admin.	0	43,418
Yosef Davis	Admin. Consult.	69.32%	15,000
Moshe Davis	Admin. Consult.	.25%	47,534
Eli Tropper	Admin. Consult.	0	5,344
TOTAL (agree to Schedule V, line 17, col. 1) (List each licensed administrator separately.)			$ 186,476

B. Administrative - Other

Description	Amount
Management Fees - Intercare	$ 40,500
TOTAL (agree to Schedule V, line 17, col. 3) (Attach a copy of any management service agreement)	$ 40,500

C. Professional Services

Vendor/Payee	Type	Amount
Personnel Planners	Unemployment Tax Svc	$ 2,848
Frost, Ruttenberg & Rothblatt	Accounting	59,173
Ungaretti & Harris	Legal	8,665
Winston & Strawn	Legal	3,157
American Express	Compliance Consulting	919
Timothy Coffey	Legal	1,150
Carolyn Williams	Legal	3,000
Econocare	Outside Purch Consultant	2,700
ManagCare	Bookkeeping	221,280
Achieve Accreditation	JCAHO Consultant	86,346
Jacobs Healthcare System	Computer	5,135
TOTAL (agree to Schedule V, line 19, column 3) (If total legal fees exceed $2500 attach copy of invoices.)		$ 394,373

D. Employee Benefits and Payroll Taxes

Description	Amount
Workers' Compensation Insurance	$ 74,547
Unemployment Compensation Insurance	37,775
FICA Taxes	218,319
Employee Health Insurance	105,950
Employee Meals	33,266
Illinois Municipal Retirement Fund (IMRF)*	
Chicago Head Tax	5,176
Other Employee Benefits	8,572
Union/Pension	24,518
Disability Insurance	2,723
Christmas Expense	2,450
TOTAL (agree to Schedule V, line 22, col.8)	$ 513,296

E. Schedule of Non-Cash Compensation Paid to Owners or Employees

Description	Line #	Amount
		$
TOTAL		$

* Attach copy of IMRF notifications

F. Dues, Fees, Subscriptions and Promotions

Description	Amount
IDPH License Fee	$
Advertising: Employee Recruitment	17,103
Health Care Worker Background Chec	1,404
(Indicate # of checks perform 201)	
Licenses, Permits & Fees	3,048
Dues & Subscriptions	5,521
Alloc-ManagCare	467
Alloc-Intercare/Mazel	36
Less: Public Relations Expense	
Non-allowable advertising	
Yellow page advertising	
TOTAL (agree to Sch. V, line 20, col. 8)	$ 27,579

G. Schedule of Travel and Seminar**

Description	Amount
Out-of-State Travel	$
In-State Travel	
Seminar Expense	1,141
Allocation from ManagCare	624
Entertainment Expense	
TOTAL (agree to Sch. V, line 24, col. 8)	$ 1,765

**See instructions.

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XIX-H. SUPPORT SCHEDULE - DEFERRED MAINTENANCE COSTS (which have been included in Sch. V, line 6, col. 3).
(See instructions.)

	1	2	3	4	5	6	7	8	9	10	11	12	13
		Month & Year			Amount of Expense Amortized Per Year								
	Improvement Type	Improvement Was Made	Total Cost	Useful Life	FY1998	FY1999	FY2000	FY2001	FY2002	FY2003	FY2004	FY2005	FY2006
1	N/A		$		$	$	$	$	$	$	$	$	$
2													
3													
4													
5													
6													
7													
8													
9													
10													
11													
12													
13													
14													
15													
16													
17													
18													
19													
20	TOTALS		$		$	$	$	$	$	$	$	$	$

XX. GENERAL INFORMATION:

(1) Are nursing employees (RN,LPN,NA) represented by a union? **Yes**

(2) Are there any dues to nursing home associations included on the cost re **Yes**
If YES, give association name and amo **Illinois Council on Long Term $8762**

(3) Did the nursing home make political contributions or payments to a political action organization? **Yes** If YES, have these costs been properly adjusted out of the cost report? **Yes**

(4) Does the bed capacity of the building differ from the number of beds licensed at the end of the fiscal year? **No** If YES, what is the capacity?

(5) Have you properly capitalized all major repairs and equipment purchase **Yes**
What was the average life used for new equipment added during this pe **10 Years**

(6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. **21,282** Line **10-2**

(7) Have all costs reported on this form been determined using accounting procedures consistent with prior reports? **Yes** If NO, attach a complete explanation.

(8) Are you presently operating under a sale and leaseback arrangem **No**
If YES, give effective date of lease.

(9) Are you presently operating under a sublease agreement? YES **X** NO

(10) Was this home previously operated by a related party (as is defined in the instructions fo Schedule VII) YES NO **X** If YES, please indicate name of the facility, IDPH license number of this related party and the date the present owners took over.

(11) Indicate the amount of the Provider Participation Fees paid and accrued to the Department of Public Aid during this cost report period. **85,410**
This amount is to be recorded on line 42 of Schedule V.

(12) Are there any salary costs which have been allocated to more than one line on Schedule V for an individual employee? **No** If YES, attach an explanation of the allocation.

(13) Have costs for all supplies and services which are of the type that can be billed to the Department of Public Aid, in addition to the daily rate, been properly classified in the Ancillary Section of Schedule V? **Yes**

(14) Is a portion of the building used for any function other than long term care services for the patient census listed on page 2, Sectio **No** For example, is a portion of the building used for rental, a pharmacy, day care, etc.) If YES, attach a schedule which explains how all related costs were allocated to these functions.

(15) Indicate the cost of employee meals that has been reclassified to employee benefits on Schedule V. $ **33,266** Has any meal income been offset against related costs? **N/A** Indicate the amoun $

(16) Travel and Transportation
a. Are there costs included for out-of-state travel? **No**
If YES, attach a complete explanation.
b. Do you have a separate contract with the Department to provide medical transportat residents? **No** If YES, please indicate the amount of income earned from su program during this reporting period. $
c. What percent of all travel expense relates to transportation of nurses and p **None**
d. Have vehicle usage logs been maintair **No**
e. Are all vehicles stored at the nursing home during the night and all other times when not in use? **No**
f. Has the cost for commuting or other personal use of autos been adjusted out of the cost report?
g. Does the facility transport residents to and from day training? No
Indicate the amount of income earned from providing such transportation during this reporting period. $

(17) Has an audit been performed by an independent certified public accounting **No**
Firm Name: The instructions for the cost report require that a copy of this audit be included with the cost report. Has this been attached? If no, please explain.

(18) Have all costs which do not relate to the provision of long term care been adjusted out out of Schedule V? **Yes**

(19) If total legal fees are in excess of $2500, have legal invoices and a summary of service performed been attached to this cost repo **Yes**
Attach invoices and a summary of services for all architect and appraisal fees